Department of Corrections
WASHINGTON STATE

OFFENDER I.D. DATA:

(Name, DOC#, DOB)

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I, _____, hereby authorize the use or disclosure of my health information as described below. The following individual or organization is authorized to make the disclosure:

NAME: _____

ADDRESS: _____

_____

_____

The type and date(s) of information to be used or disclosed is as follows:

_____

_____

_____

_____

_____

☐ Substance abuse/CD treatment records are also being requested (requires DOC form 14-303, Chemical Dependency Consent for Release of Information, or equivalent)

Purpose for disclosure: _____

I understand that the information in my health record may include information relating to sexually transmitted infections, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

This information may be disclosed to and used by the following individual or organization:

NAME: _____

ADDRESS: _____

_____

_____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____(if left blank, authorization will expire six (6) months from signing).

I understand that authorizing the disclosure of this health information is voluntary. I may refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524 and RCW 70.02. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and may not be protected by federal or state confidentiality rules. If I have questions about disclosure of my health information, I may contact the RHIT/designee of the facility: _____.

_____ _____

Signature of Patient
(Do not sign if form is not complete)

Date
(Patient to complete)

_____ _____ _____

Last four digits of SSN

Date of Birth

DOC Number

Requesting provider: _____ Date mailed/faxed: _____

State law (RCW 70.02; RCW 70.24.105; RCW 71.05.390) and/or federal regulations (42 CFR Part 2; 45 CFR Part 164) prohibit disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.

DOC 280.500 DOC 600.020 DOC 620.380 DOC 640.020 DOC 670.020 DOC 890.600